471-000-99 Medicaid Claim Adjustment and Refund Procedures

This appendix outlines the procedures for provider-initiated requests for claim adjustments and refunds on processed Medicaid claims.

Processed Medicaid claims are reported on the Medicaid Remittance Advice (Form MCP-248) or the standard electronic Health Care Claim Payment/Advice (ASC X12N 835) transaction. The reason code on the remittance advice indicates the reason for claim denial or payment reduction. For an example of the Medicaid Remittance Advice, see 471-000-85.

Questions regarding Medicaid claim status, payment, or denial, may be directed to Medicaid Inquiry at 1-877-255-3092 or 471-9128 (in Lincoln), option 1, from 8:00 a.m. to 5:00 p.m. Central Time, Monday through Friday. Questions regarding pharmacy drug claims may be directed to the ACS Helpdesk at 1-866-506-4378.

The Department may also initiate claim adjustments and refund requests, as needed.

MEDICAID CLAIM ADJUSTMENTS:

Provider-initiated claim adjustment requests include submission of corrected claim information, required documentation, and clarification of services or circumstances related to the original processed claim. Providers may request a claim adjustment on paper or electronically using the procedures in this section. **Note: Pharmacies use the Department's point-of-sale system to adjust drug claims. Separate instructions are included for pharmacy drug claims.**

> Third Party Resource Denials: When a claim is denied for third party health or casualty resources, the claim must be filed with all identified third party resources. Third party health resources are identified on the Medicaid Remittance Advice. Third party casualty resources are identified on Form MCP575, "Casualty Insurance Policy Information Sheet (for an example and explanation, see 471-000-100).

After the Department processes the claim adjustment request, providers are notified of non-approved requests on the Electronic Claim Activity Report or on paper. Approved claim adjustments are reported on –

- the Medicaid Remittance Advice (Form MCP248) or standard electronic Health Care Claim Payment/Advice (ASC X12N 835) transaction when the adjustment results in a payment change or a change to a data field reported on the remittance advice form or electronic transaction; or

- the Medicaid Remittance Advice "Refund Request" (Form MCP248) or the electronic refund request report when the adjustment results in a refund due.

Procedures for Submitting Claim Adjustment Requests on Paper:

Providers must submit claim adjustment requests within 90 days of the payment/denial date on the Medicaid remittance advice, unless the claim adjustment request is related to third party health or casualty resources. Timelines for filing claim adjustment requests when third party resources are involved are in 471 NAC 3-004.06.

To submit a request for claim adjustment on paper, use the following procedures. Do not request adjustment by submitting a new claim as this will result in denial as a 'duplicate claim.

1. Identify the submittal as "Claim Adjustment Request;"

2. Identify the Medicaid claim to be adjusted –

- If a copy of the Medicaid Remittance Advice is available, photocopy the page on which the claim appears and highlight in yellow or circle the Medicaid claim number;
- If the adjustment is needed due to denial for third party casualty resources and the "Casualty Insurance Policy Information Sheet" (Form MCP-575) is available, submit a photocopy of the form; or
- If a copy of the Medicaid Remittance Advice or Casualty Insurance Policy Information Sheet is not available, identify the Medicaid claim number, the Medicaid provider number, the client's Medicaid number, date of service, and claim charge;

3. Provide the information supporting the adjustment request –

- To correct information submitted on the identified claim, make the corrections on the Medicaid Remittance Advice photocopy or clearly identify the specific line and correction needed;
- To provide additional documentation or to clarify services, attach appropriate documentation or justification;
- If the adjustment is needed due to denial for third party health resources, attach a copy of the health insurance remittance advice, explanation of benefits, denial, or letter; or
- If the adjustment is needed due to denial for third party casualty resources, attach a copy of the explanation of benefits, payment check, letter from attorney, and similar documentation from the casualty resource;
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4. Sign, date, and include the provider's telephone number on the adjustment request; and

5. Mail the adjustment request to: Health and Human Services Finance and Support
Medicaid Claims Processing
P.O. Box 95026
Lincoln, NE 68509-5026

Procedures for Submitting Claim Adjustment Requests Electronically:

Providers must submit claim adjustment requests within 90 days of the payment/denial date on the Medicaid remittance advice, the claim adjustment request is related to third party health or casualty resources. Timelines for filing claim adjustment requests when third party resources are involved are in 471 NAC 3-004.06.

To submit an electronic claim adjustment request, use the following procedures. Do not request adjustment by submitting a new claim as this will result in denial as a 'duplicate claim.

1. Use the ASC X12N 837 Health Care Claim as outlined in the appropriate ASC X12N Implementation Guide and the applicable Nebraska Medicaid Companion Guide;

2. Identify the Medicaid claim number to be adjusted in the "Original Reference Number" segment;

3. Use the correct frequency code for the type of adjustment – replacement, late charges, or void –

- A replacement claim is used when the identified claim requires change or correction. When submitting a replacement claim, do not also submit a request to void the claim and do not submit only the lines with corrections. Resubmit the entire corrected claim. The replacement claim will be processed as an adjustment to the identified claim; or
- A late charge is used to bill a service that was not entered on the identified claim. Submit only the new service(s). Do not submit charges that were previously billed on the identified claim. Late charges can not be submitted on inpatient claims, nursing facility claims, and claims for encounter services. These claims must be submitted as replacements; or
- A voided claim is used when the identified claim will not be replaced. The voided claim will be processed for refund. Note: A voided claim should not be used for third party casualty cases (see 471 NAC 3-004.09); and

4. Provide the information supporting the adjustment request. Documentation may be submitted electronically or on paper. When submitting paper attachments, the transaction must include the Identification Code (referred to as the "Attachment Control Number") in the appropriate PWK segment –

- To correct information submitted on the identified claim, submit corrections as outlined in Step 3;
- To provide additional documentation or to clarify services, submit appropriate documentation or justification; or
- If the adjustment is needed due to denial for third party health or casualty resources, complete the Coordination of Benefits (COB) segments. If the COB information is not submitted electronically, the required documentation may be submitted as a paper attachment. For third party health resources, a copy of the health insurance remittance advice, explanation of benefits, denial, or letter is required. For third party casualty resources, a copy of the insurance explanation of benefits, payment check, letter from attorney, and similar documentation from the resource is required; and

5. Submit the adjustment request using your usual method for electronic claim submission. For additional information on submitting electronic transactions, see 471-000-50.

Procedures for Submitting Adjustments on Pharmacy Drug Claims:

Pharmacies submit drug claim adjustments through the Department's point-of-sale system by reversing the original claim and, if appropriate, submitting a rebill (new claim). Claim reversals may be submitted through the point-of-sale system within one year from the payment/denial date on the Medicaid Remittance Advice. If the claim can not be reversed through the point-of-sale system, the provider should contact the Department for assistance.

MEDICAID REFUNDS:

It is the responsibility of the provider to submit refunds to the Department upon discovering duplicate or erroneous Medicaid payments. The provider should not wait until a refund request is received from the Department before submitting refunds. Providers may refund the Department by submitting a check for the amount of the refund or by requesting a reduction to future payments (warrant reduction). Submission of a voided electronic claim will also initiate a refund request, but should not be used for third party casualty payment refunds (see 471 NAC 3-004.09). Procedures for refunds are included in this section. **Note: Pharmacies use the Department's point-of-sale system to process refunds on drug claims. Separate instructions are included for pharmacy drug claims.**

Payment From Third Party Resources: When the provider receives payment from a third party resource on a claim previously paid by Medicaid, the provider must refund the Department within 30 days. If the third party payment equals or exceeds the Medicaid payment on the claim, the total Medicaid payment must be refunded. If the third party payment is less than the Medicaid payment on the claim, the total third party payment must be refunded.

The Department may also initiate requests for Medicaid refunds. Providers are notified of the refund request by letter, Form MC-11D "Return of Warrant", the Medicaid Remittance Advice "Refund Request" (Form MCP248), or the electronic refund request report. Providers have 30 days from the date on the notification to refund the Department. Providers may submit a check for the amount of the refund or request a reduction to future payments (warrant reduction) using the procedures in this appendix.

Procedures for Submitting Refunds by Check:

Providers may initiate a refund or respond to a Department-requested refund request by submitting a refund check. After Department processing, providers will not receive notification of the refund on the Medicaid remittance advice.

1. Identify the submittal as a "Refund;"

2. Identify the Medicaid claim being refunded –

- If a copy of the Medicaid Remittance Advice is available, photocopy the page on which the claim appears and highlight or circle the Medicaid claim number; or
- If a copy of the Medicaid Remittance Advice is not available, identify the Medicaid claim number, the client's Medicaid number, the Medicaid provider number, date of service, and claim charge;

3. Explain the reason for the refund and, if applicable, the service lines being refunded;

4. If the refund is due to payment by a third party resource, attach a copy of the third party remittance advice and, for third party casualty refunds, attach a copy of the check and accompanying documentation from the casualty resource, if available;

5. Attach a check for the amount of the refund. Note: Providers may submit refunds by returning a State of Nebraska warrant only if the warrant amount is equal to the full amount of the refund due;

6. Sign, date, and include the provider's telephone number on the refund submittal; and

7. Mail the refund submittal to: Health and Human Services Finance and Support
Financial Services Division
P. O. Box 95026
Lincoln, NE 68509-5026

Procedures for Requesting Warrant Reduction:

Providers may initiate a refund or respond to a Department-requested refund by requesting a reduction to future payments (warrant reduction). After Department processing, the provider will receive notice of the warrant reduction on the Medicaid Remittance Advice (MCP248) or the standard electronic Health Care Claim Payment/Advice (ASC X12N 835) transaction.

To Request a Warrant Reduction by Phone: Contact the Financial Services Division of HHS F&S, at (402) 471-9176. Provide the Medicaid claim number, your Medicaid provider number, the client's Medicaid number, date of service, the refund amount and reason for refund.

To Request a Warrant Reduction on Paper:

1. Identify the submittal as a "Warrant Reduction Requested."

2. Identify the Medicaid claim being refunded –

- If a copy of the Medicaid Remittance Advice is available, photocopy the page on which the claim appears and highlight or circle the Medicaid claim number; or
- If a copy of the Medicaid Remittance Advice is not available, identify the Medicaid claim number, the client's Medicaid number, the Medicaid provider number, date of service, and claim charge;

3. Explain the reason for the refund and, if applicable, the service lines being refunded;

4. If the refund is due to payment by a third party resource, attach a copy of the third party remittance advice and, for third party casualty refunds, attach a copy of the check and accompanying documentation from the casualty resource, if available;

5. Sign, date, and include the provider's telephone number on the refund submittal; and

6. Mail the refund submittal to:

Health and Human Services Finance and Support
Financial Services Division
P. O. Box 95026
Lincoln, NE 68509-5026

Procedures for Initiating a Refund Request Electronically:

Providers may initiate a refund by submitting an electronic voided claim. See instructions for submitting electronic claim adjustments in the Medicaid Claim Adjustments section of this appendix. Note: This procedure should not be used for third party casualty payment refunds (see 471 NAC 3-004.09). After Department processing, a refund request will appear on the Medicaid Remittance Advice "Refund Request" (Form MCP248) or the electronic refund request report. The provider responds to the refund request by submitting a check for the amount of refund or requesting a warrant reduction.

Procedures for Submitting Refunds for Pharmacy Drug Claims:

Pharmacies submit refunds on drug claims through the Department's point-of-sale system by submitting a reversal of the original claim. In some cases, a claim can not be reversed through the point-of-sale system and the pharmacy uses the procedure outlined for submitting refunds by check or by requesting a warrant reduction.

Example of Refund Request Form MC-11D, "Return of Warrant:"

Nebraska Department of Social Services

REQUEST FOR MEDICAL REFUND / CANCELLATION
RETURN OF WARRANT

FORM MC-11D

Fill out as completely as possible. Make check payable to the Nebraska Department of Social Services and mail, along with white copy, to Finance and Accounting, Nebraska Department of Social Services, Box 95026, Lincoln, NE 68509-5026.

I. PROVIDER / DESCRIPTION

Name			Provider Number	
Address			Patient Acct. No.	Amount Billed $
			Patient Acct. No.	Amount Billed $
City	State	Zip Code	Patient Acct. No.	Amount Billed $

II. CLIENT DESCRIPTION

Name	Case Number	Identification Number

III. MEDICAL PAYMENTS DESCRIPTION

(If available, attach copy of the listing of claims paid which was mailed with the original payment.)

Warrant Number	Warrant Date	Amount Paid $
Billing Claim Number	Period of Service From:	To:
Warrant Number	Warrant Date	Amount Paid $
Billing Claim Number	Period of Service From:	To:
Warrant Number	Warrant Date	Amount Paid $
Billing Claim Number	Period of Service From:	To:

IV. REFUND INFORMATION

Check/Warrant Number	Date	Total Amount $
Source: A ☐ Provider B ☐ Recipient C ☐ State Warrant Return D ☐ Third Party ☐ Other_____		Total Amount of Check $

Reason Codes (Check One Box)

A ☐ Medicare	E ☐ Probate Collection	J ☐ Data Entry Error/Agency Error
B ☐ Health Insurance	F ☐ Fraud	K ☐ Child Support
C ☐ Casualty Insurance	G ☐ Abuse	S ☐ Subrogation
D ☐ Responsible Relative	H ☐ Duplicate Billing by Provider and Payment By Medicaid	☐ Other-Explain in Reason Portion (Below)

Reason:

Prepared By	Date	Received / Adjusted by	Date

In accordance with the Nebraska Medicaid Manual, Section 471-NAC-3-001.08: When the Nebraska Department of Social Services requests a refund of all or part of a paid claim, the provider shall have 45 days to refund the requested amount, to show that the refund has already been made or show why the provider believes that the refund request itself may be in error. Failure to respond within the specified 45 days may be considered cause to withhold future provider payments until the situation in question is resolved.

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MC-11D Rev. 11/91 (57018)